Asthma Action Plan

A PARTNERS IN ASTHMA CONTROL FOR RHODE ISLAND FORM
adapted from the NHLBI

PATIENT NAME _____ **D.O.B.** ___/___/___

HEALTH PLAN _____

DOCTOR'S NAME _____

DOCTOR'S PHONE _____

PATIENT'S PERSONAL BEST PEAK FLOW READING _____

EMERGENCY
❑ **911** OR ❑ _____

PARENT/GUARDIAN _____

PHONE _____ **PAGER** _____

ADDRESS _____

PARENT #2/RELATIVE _____

PHONE _____ **PAGER** _____

GREEN = GO

- ❑ BREATHING IS GOOD
- ❑ NO COUGH OR WHEEZE
- ❑ CAN WORK/PLAY

OR

- ❑ PEAK FLOW NUMBER ABOVE (GREATER THAN 80% OF BEST) _____

NOTES: _____

USE THESE DAILY CONTROLLER MEDICINE(S)

MEDICINE	HOW MUCH TO TAKE	WHEN TO TAKE IT

BEFORE SPORTS OR PLAY, USE THIS MEDICINE: _____

YELLOW = CAUTION

- ❑ COUGH
- ❑ WHEEZE
- ❑ TIGHT CHEST
- ❑ WAKE UP AT NIGHT
- ❑ FIRST SIGN OF COLD

OR

- ❑ PEAK FLOW NUMBER _____ TO _____

CALL DOCTOR?
❑ YES ❑ NO

USE THESE MEDICINE(S) TO KEEP FROM GETTING WORSE

MEDICINE	HOW MUCH TO TAKE	WHEN TO TAKE IT

SPECIAL INSTRUCTIONS:

RED = STOP

- ❑ MEDICINE IS NOT HELPING
- ❑ HEART RATE OR PULSE IS VERY FAST
- ❑ NOSE OPEN WIDE WHEN BREATHING
- ❑ HARD TO WALK OR TALK IN SENTENCES
- ❑ RIBS OR NECK MUSCLES SHOW WHEN BREATHING
- ❑ LIPS OR FINGERNAILS TURN GRAY OR BLUE

OR

- ❑ PEAK FLOW NUMBER BELOW _____

GET HELP FROM A DOCTOR NOW!!!!!

MEDICINE	HOW MUCH TO TAKE	WHEN TO TAKE IT

SPECIAL INSTRUCTIONS:

PHYSICIAN SIGNATURE (REQUIRED) _____ **DATE** _____

PRINT NAME _____ **COPIES TO:** ❑ **PATIENT** ❑ **SCHOOL NURSE/TEACHER** ❑ **PHYSICIAN**